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**FISCAL IMPACT STATEMENT**

**LS 7351**

**BILL NUMBER:** SB 464

**NOTE PREPARED:** Jan 21, 2015

**BILL AMENDED:**

**SUBJECT:** Mental Health Drugs.

**FIRST AUTHOR:** Sen. Miller Patricia

**FIRST SPONSOR:**

**BILL STATUS:** As Introduced

**FUNDS AFFECTED:** X GENERAL  
DEDICATED  
X FEDERAL

**IMPACT:** State & Local

**Summary of Legislation:** This bill has the following provisions:

- A. *Use of Long-Acting, Nonaddictive Medication in Community Supervision* – It provides that addictions counseling, inpatient detoxification, and long-acting, nonaddictive medication may be required to treat opioid or alcohol addiction as a condition of parole, probation, community corrections, pretrial diversion, or participation in a problem-solving court.
- B. *Expansion of Medicaid Benefits* – It includes inpatient substance abuse detoxification services as a Medicaid service. It prohibits the Office of Medicaid Policy and Planning (OMPP) from requiring prior authorization for a drug that is a nonaddictive medication assistance treatment drug being prescribed for the treatment of substance abuse. It requires OMPP to include coverage for addictive medication assistance treatment drugs being prescribed for substance abuse treatment but allows for prior authorization. It requires coverage under the Indiana Check-up Plan of nonaddictive and addictive medication assistance treatment drugs prescribed for the treatment of substance abuse.
- C. *Certified Community Mental Health Centers*– It authorizes applications for a new opioid treatment program run by a certified community mental health center.
- D. *Repeal of Department of Correction (DOC) Requirement* – It repeals the requirement that the DOC estimate, prior to March 1, 2015, the amount of any operational savings that will be realized in FY 2015 from a reduction in the number of individuals who are in the custody or made a ward of DOC.

**Effective Date:** July 1, 2015.

### **Summary of NET State Impact:**

The fiscal impact of this bill would depend on whether existing opioid treatment programs (OTP) would apply to become Medicaid providers and bill the Medicaid program for substance abuse treatment drugs - addictive or nonaddictive. FSSA has reported that along with the additional cost of the drugs, providing transportation to and from geographically limited treatment providers could exceed the additional cost of the drugs required by the bill. The Division of Mental Health and Addiction (DMHA) reported that expanded treatment options could reduce emergency department use and inpatient admissions for substance abuse.

It is not certain what the impact of the bill would be on the Healthy Indiana Plan (HIP) waivers - either the currently operating HIP 1.0 waiver or the HIP 2.0 Medicaid expansion waiver pending approval from the federal government.

Expansion of the number of opioid treatment programs through the community mental health centers would have a fiscally neutral effect on the DMHA.

**Explanation of State Expenditures:** *Use of Medication-Assisted Treatment in Community Supervision:* The bill language is permissive and would allow chemical addiction treatment to be required for addicted offenders who are on parole, probation, in community corrections, on pretrial diversion, or participating in a problem-solving court. While the bill specifies that medication-assisted treatment may include long-acting nonaddictive medication, it would also allow addictive medication-assisted treatment medications. The costs of requiring participation will depend on the orders of the DOC or a court, the number of addicted offenders that might currently qualify for Medicaid, and if all the treatment costs would be included as allowable benefits within the currently operating HIP 1.0, and the HIP 2.0 model proposed for the statewide Medicaid expansion under the Affordable Care Act and when an expansion would be implemented. (Other provisions of the bill would add required services to the Medicaid State Plan or require reimbursement for addiction treatment therapies.)

*New Opioid Treatment Programs:* The bill would allow certified community mental health centers (CMHC) only to apply to the DMHA to operate a new opioid treatment program. The DMHA would have administrative and regulatory oversight responsibility for up to 25 additional treatment programs. DMHA reported that an expansion of this size would require an additional 2.5 full-time equivalents with a personal services cost of approximately \$157,960. The cost estimate does not include equipment supplies or office space associated with the additional FTEs. Additional administrative costs in this program are cost-neutral to DMHA since administrative costs associated with the opioid treatment programs are billed back to the programs on a per person basis. (Last year, the OTPs were billed \$26 per person for DMHA administration costs.) The ultimate fiscal impact of this provision would depend on the number of CMHCs that would choose to apply to operate an OTP and how CMHC fees are structured to recover the DMHA administrative costs - it could transfer these costs to other funding streams.

### *Expansion of Medicaid Benefits-*

*Administrative costs:* The Family and Social Services Administration (FSSA) may be required to submit Medicaid State Plan amendments (SPA) to add inpatient substance use detoxification services as a State Plan service and methadone as a substance abuse maintenance treatment. The bill may also require that HIP 1.0 and 2.0 waivers be amended in order to include addictive and nonaddictive substance abuse treatment drugs in the plan benefits. If amendments are required, SPAs and waiver amendments are a core function of the

Medicaid program and should be accomplished within the level of resources currently available to the FSSA.

*Inpatient Substance Abuse Detoxification Services:* FSSA reported that Medicaid currently provides reimbursement for inpatient detoxification services. DMHA reported that the degree of medical necessity that is applied by the limited number of providers for these specialized services may be limiting the current pool of patients that have services reimbursed. DMHA reported that the medical necessity criteria applied currently may be that the patient is at risk of death without detoxification. If the bill expands the extent of medical necessity to a lower risk criteria, then the number of Medicaid-enrolled patients seeking detoxification services could expand significantly. The fiscal impact would depend on whether the bill would require a lower level of medical necessity than is currently applied and the number of detoxification providers that would be available to provide inpatient services to addicted Medicaid-enrolled individuals.

*Methadone as a Maintenance Treatment for Opioid Abuse:* The bill would require the Medicaid program to cover addictive medication-assistive treatment drugs - this would include methadone and buprenorphine/naloxone. FSSA reported that currently Indiana Medicaid regulations do not allow reimbursement for methadone as a substance abuse maintenance drug. It is reimbursed for substance abuse treatment only when it is used by CMHCs in detoxification treatment or if it is prescribed for pain management. (Under current pharmacy laws, it is prohibited for a pharmacist to fill an addictive prescription for known drug abusers; the pharmacist would be subject to disciplinary actions by the Board of Pharmacy.) Buprenorphine/naloxone is reimbursed for substance abuse treatment by Medicaid only if prescribed by specified physicians.

The bill would allow methadone to be dispensed without prior authorization (PA) if prescribed for the treatment of substance abuse. It would further require PA for methadone prescriptions written for the treatment of pain. It is unlikely that Medicaid would remove methadone from PA requirements. It is an opiate and subject to PA due to the possibility of fraudulent practices, abuse, and overuse. Removing PA could potentially allow for early refills. Further, there would be no other way to distinguish what condition the prescription is intended to address. Methadone used in OTPs is dispensed by the program in a liquid form - the programs do not write prescriptions for methadone. The cost of this addition would depend on the number of OTPs that would apply to become Medicaid providers and bill the program for methadone or if the CMHCs would begin to bill for methadone administered in their OTP.

*Transportation Costs:* FSSA reported that if methadone is added to the Medicaid program as an allowable maintenance drug for the treatment of opioid substance abuse, the transportation expense required could exceed the cost of the drugs. Methadone is a relatively inexpensive drug. Medicaid enrollees statewide could enter treatment programs and have transportation to the geographically limited OTPs provided on a daily basis by the Medicaid program. (Patients are known to drive an hour or more each way to access methadone treatment programs.)

#### Additional Information:

There are currently 13 OTPs operating in the state. DMHA has reported that 8 of the providers take third-party payments; 3 providers are community mental health centers; and that other than the CMHCs, none of the treatment programs are enrolled as Medicaid providers. DMHA reported that the CMHCs do not bill Medicaid for OTP services, instead using federal block grant monies for services that are provided to high-profile opioid drug abusers, such as pregnant women, IV drug abusers, and HIV-positive individuals. Medicaid does not currently reimburse for methadone used for opioid abuse treatment.

DMHA reported that 15,242 total patients were treated in the opioid treatment programs in CY 2013. About 69%, or 10,464 patients, were Indiana residents. Of the Indiana residents, 1,274 were served by state-funded programs through the CMHC.

*Opioid Treatment Drugs:* Naltrexone (Vivitrol) is a nonaddictive, long-lasting drug that is injected on a monthly basis to treat individuals with an addiction to opioid or alcohol. The extended release version of the drug that is used for opiate addiction treatment is reimbursed by Medicaid at approximately \$1,100 per injection.

Buprenorphine/naloxone is an addictive drug used to treat opioid addiction. DMHA reported in 2012 that the wholesale cost of the drug is \$17.00 per 100mg. Clients in OTPs were reported to pay \$70 to \$300 per week for this drug. Medicaid reimbursement will be reported when available.

Methadone is an addictive drug that was reported to cost in 2012, \$11.49 per 100mg. Clients in opioid treatment programs were reported to pay in a range of \$65 to \$101.50 per week.

**Explanation of State Revenues:**

**Explanation of Local Expenditures:** Probation programs and problem-solving courts would be permitted to require offenders to receive naltrexone extended release as an opioid abuse treatment medication.

**Explanation of Local Revenues:**

**State Agencies Affected:** Department of Corrections, FSSA, DMHA.

**Local Agencies Affected:** Probation programs and problem-solving courts.

**Information Sources:** FSSA, DMHA, Minutes of the July 30, 2014 meeting of the Interim Study Committee on Public Health, Behavioral Health, and Human Services.

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